

SDI Online Tutorial: Physician/Practitioner Online Access Information

Overview

- Create an SDI Online Account
- Access SDI Online Accounts
- Add a Treatment Address
- Assign a Medical Representative
- Submit a DE 2501 Part B Certificate
- Submit a DE 2525xx Supplementary Certificate

Create an SDI Online Account

Disability Insurance

- How to File a DI Claim
- DI Eligibility
- DI Program Information
- DI Benefit Amounts
- New! SDI Online**

More Disability Insurance Information

Employers

- Employer Eligibility
- Employer Requirements
- Voluntary Plans
- Workers' Compensation
- SDI Online

More Employers Information

Paid Family Leave

- How to File a PFL Claim
- PFL Eligibility
- PFL Program Information
- PFL Benefit Amounts
- New! SDI Online**

More Paid Family Leave Information

Physicians/Practitioners

- Basics for Physicians/Practitioners
- Becoming an Independent Medical Examiner
- Physicians/Practitioners
- Physicians/Practitioners Forms and Publications
- SDI Online**

More Physicians/Practitioners Information



Important Links

- About the Program
- DI Eligibility
- PFL Eligibility
- New! SDI Online**
- Forms and Publications

To create an SDI Online account:

- Visit www.edd.ca.gov.
- Select **Disability**.
- Under Important Links, select **SDI Online**, or
- Under Physician/Practitioners, select **SDI Online**.



Language: English ▼

Contact SDI

Online

By Location

By Phone

Telephone Numbers
Automated Info System

SDI Registration Instructions

Important: You are required to have a valid e-mail address to register in SDI Online.

Welcome to State of California Employment Development Department's (EDD) State Disability Insurance (SDI) Online Registration process.

The Disability Insurance (DI) Branch of EDD provides four registration choices. Select the registration option for the type of account that you need to access the system.

CLAIMANTS

Select this option to file a DI or Paid Family Leave (PFL) claim, access your personal claim information, and view payment history. You will need to provide your Social Security Number and California Driver License or State ID Number to complete the registration. The registration system is available Monday through Friday, between 7 a.m. and 7 p.m.

[Continue to Claimant Registration](#)

PHYSICIAN/PRACTITIONERS

Select this option if you are a Physician or Practitioner who certifies DI or PFL claims for your patients. The SDI Online allows authorized Physicians and Practitioners and their designated representatives to view their patient's initial claim for benefits, submit DI and PFL claim certifications, and view their claim certification history. You will need to provide your medical license information as filed with the California Department of Consumer Affairs in order to complete registration. Physicians and Practitioners will need to first register for an account before they can designate representatives for their account.

[Continue to Physician/Practitioner Registration](#)

This will take you to the **SDI Registration Instructions** page. Select the **Continue to Physician/Practitioners Registration** hyperlink.




Security Check

*Indicates Required Field

Security Check

Snell

social

-  Try Another
-  Vision Impaired
-  Help

This Security Check allows us to:

Ensure Restricted Access to Registration

Automated programs known as "Bots" cannot read distorted text as well as humans. The Security Check helps prevent automated programs from blocking other users from registering for accounts with the EDD.

Provide an Audio Option for Visually Impaired Customers

An audio option allows visually impaired customers to hear a set of eight (8) digits that can be entered instead of the word challenge.

*Please type both words separated by a space below:

You do not have permission to access this website if you are using an automated program.

Next

You will see the **Security Check** page requesting that you type the words shown in the text box.

- Then select the **Next** button on the bottom right. *(If you have difficulty viewing the words you can select the **Try Another** button located to the right of the word box.)*

Physician/Practitioner: Terms and Conditions

Terms and Conditions

Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If "I Do Not Agree" is selected, you will not be able to establish an online account.

These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.

If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.

By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.

The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.

I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.

I Do Not Agree

I Agree

Next you will see the **Physician/Practitioner: Terms and Conditions** page.

Scroll to the very bottom of the page once all the information has been read and select the **I Agree** button, located at the bottom of the page.

Physician/Practitioner: Account Verification Information

*Indicates Required Field

If you already have an account with SDI, [log in here](#).

Personal Information

Please enter your full legal name to register.

*First Name:

Middle Name:

(if you have no middle name, leave blank)

*Last Name:

Suffix:

(if you have no suffix, leave blank)

*E-mail Address:

*Re-Type E-mail Address:

*Date of Birth: (MMDDYYYY)

*Last four digits of Social Security Number:

Physician/ Practitioner Information

*License Type: Select

*Physician/Practitioner License Number:

NPI Number:

*License Expiration Date: (MMDDYYYY)

Medical School Name:

Medical School Year Graduated:

Address and Phone Number

Please enter the address and phone number as provided to the Department of Consumer Affairs.

☒ US ☐ International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

*Phone Number: Ext: ☐ Check here if the phone number is international
(No dashes or spaces)

You will now be directed to the **Physician/Practitioner: Account Verification Information** page.

- Fill out all of the information requested. The red asterisks indicate required fields that **must** be completed. Once all the information is filled out, select the **Next** button located at the bottom right side of the page.

When creating an SDI Online account, remember to:

- Enter personal medical information as it appears in the registration with your Medical Board.
- Enter the mailing address the Medical Board has on file.

Note: the user will be able to add treatment addresses once the account is created.

Physician/Practitioner: Setup Security Profile Information

*Indicates Required Field

Account Information

Enter a Username and Password. Do not share your password with anyone.

*Username:
(must be 6 to 15 characters, no special characters)

*Password: (case sensitive)
(must be 8 to 12 characters long, including an uppercase letter, a lowercase letter, a number, and one of the following: ! @ # \$ % ^ & * ())

*Re-Type Password: (case sensitive)

*Password Hint:

Choose your Security Questions and enter your answer to each question. This will be part of your Account Recovery Options.

*Question 1: Please select your question

*Answer to Question 1:

*Question 2: Please select your question

*Answer to Question 2:

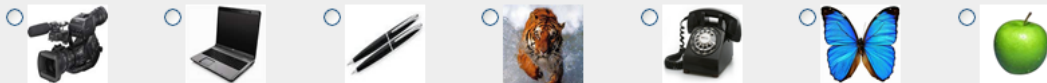
*Question 3: Please select your question

*Answer to Question 3:

*Question 4: Please select your question

*Answer to Question 4:

*Choose your Personal Image and enter a Personal Image Caption for it. The image along with your image caption helps you know that you are at a valid EDD site and that it is safe to enter information. [Refresh to get a new set of personal images.](#)



*Personal Image Caption:

The **Physician/Practitioner: Setup Security Profile Information** page will display. Once all information is filled out in each field:

- Select a Personal Image.
- Then enter a word or phrase of your choice in the Personal Image Caption box.

Once completed, select the **Next** button located at the bottom right side of the page.

Note: The SDI Online system will remember the computer used to log in. If the user accesses their account through a different computer, they will have to correctly answer to these security questions.

Be sure to make note of your Username, Password, Security Questions, and Personal Image to ensure easy access when using the SDI Online system.

Physician/Practitioner: Personal Profile Information

*Indicates Required Field

Communication Preferences

Indicate below how you prefer to be notified. Some EDD forms are not available online and will be sent through the US Postal Service.

- *Preferred Communication:
- ☒ I prefer to be notified by e-mail.
 - ☐ I prefer to be notified by paper mail
 - ☐ I do not want to receive notifications. I will be reviewing the items in my message center regularly

Submit

Cancel

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

You will arrive at the **Physician/Practitioner: Personal Profile Information** page.

- Select your preferred method of communication.
- Select **Submit**.

Account Setup Confirmation

Successful Account Creation Notification

Your account has been created and your EDD Customer Account Number is [redacted]. A notification has been sent to you via e-mail. If you do not receive an email, please check your junk/spam folder. To ensure e-mails from the EDD appear in your inbox, add noreply@edd.ca.gov to your address book.

[Login](#)

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

You will arrive at the **Account Setup Confirmation** page where you will receive a Successful Account Creation Notification and an EDD Customer Account Number.

Congratulations!
You are now registered with SDI Online.

To log in to your account, select the **Login** button.

Access SDI Online Accounts



State of California

Employment Development Department

Contact EDD | Forms & Publications | Online Services

Search

This Site California

Home

Unemployment

Disability

Jobs & Training

Payroll Taxes

Labor Market Info

New Online Services

Services have been enhanced and automated. You can now file a claim for Disability Insurance and Paid Family Leave online, submit forms online, and view claim information online. To register, visit:

New! SDI Online

New! SDI Online En Español

New! Troubleshooting: Accessing SDI Online

Previously registered with SDI Online?

If you have previously registered with SDI Online and want to log in to your account, visit:

SDI Online Login

SDI Online Login En Español



Disability Insurance

- How to File a DI Claim
- DI Eligibility
- DI Program Information
- DI Benefit Amounts
- New! SDI Online

More Disability Insurance Information



Paid Family Leave

- How to File a PFL Claim
- PFL Eligibility
- PFL Program Information
- PFL Benefit Amounts
- New! SDI Online

More Paid Family Leave Information

To access SDI Online accounts:

- Go to www.edd.ca.gov.
- Select **Disability**.
- Select the **SDI Online Login** hyperlink.
- Log in with the previously created Username and Password (user may be asked to answer security questions).

Employment
Development
Department
State of California

[Skip to main content](#)
[Help](#) | [Login](#)

language: English

Contact SDI

Online
 By Location
 By Phone
 Telephone Numbers
 Automated Info
 System

SDI Online Login

***Indicates Required Field**

*Username:

[Forgot username?](#)
[Register for](#)

SECURITY REMINDER
 Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.

On the **SDI Online Login** page:


- Enter your Username and select the **Submit** button to be taken to the **Home** screen.
- Enter your Password on the next screen and select **Log In**.

Note: the Personal Image helps identify that the user has entered the correct Username.

Confirm Your Personal Image and Log In

***Indicates Required Field**

Verify your personal image and enter your password.

Personal Image:
 

Personal Image Caption: test

Username:

*Password: (case sensitive)

[Forgot your personal image?](#)
[Incorrect personal image showing?](#)
[Forgot password?](#)

Physician/Practitioner Home

***Indicates Required Field**

| License Information | |
|---------------------|----------------|
| Licensee Name | License Number |

Message Center

[Items Requiring Attention and Notices](#) [New: 1 , Total: 3]
[Saved Drafts](#) [Total: 7]

Claimant/Claim Search

*Search By: Claim ID

Claim ID
 Claimant Receipt Number
 My Receipt Number

Claimant/Claim Results

At the **Home** page, under the Search section, the user can:

- Search by “Claim ID” to view forms to be submitted.
- Search by “My Receipt Number” to view the form submitted by the user.
- Search by “Patient Receipt Number” to submit a DE 2501 Part B Initial Claim form:
 - In order to submit the DE 2501 Part B online, the claimant must have submitted the DE 2501 Part A – Claimant Statement.
 - The user will need the claimant’s submission Receipt Number.
- The user must also enter the claimant’s last name to begin the search.

MAIN MENU

Home
Inbox
Saved Drafts
Manage My Profile
Contact Us

Home

*Indicates Required Field

License Information

Message Center

Inbox

It is important to read all messages from EDD carefully. Select the subject hyperlink below to view the message.

No Results Found

Saved Drafts

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the Delete action.

No Results Found

The Main Menu appears on most screens and has many options.

- **Inbox:** will take the user to the Message Center. The user will be able to access their messages from the EDD.
- **Saved Drafts:** users can see all the saved draft forms that have been started but have not yet been submitted to the EDD.

Note: forms in Saved Drafts will be deleted after 30 days.



MAIN MENU

Home
Inbox
Saved Drafts
Manage My Profile
Contact Us

Home

*Indicates Required Field

License Information

Physician/Practitioner Update Personal Profile Information

*Indicates Required Field

Physician/Practitioner Information

Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs (DCA). DCA will provide EDD with your updated address when the next license validation is done.

Contact Us

*Indicates Required Field

Disability Insurance General Questions

For answers to general questions, please visit our Frequently Asked Questions page at: <http://www.edd.ca.gov/Disability/FAQs.htm>. If you have a question that is not addressed or if you would like to report fraud, you may contact the State Disability Insurance office by completing the information below.

*Category:

*Message:

*How do you want to receive the response?

- **Manage My Profile:** users can update profile information, including treatment addresses and medical representatives.
- **Contact Us:** users are able to submit questions to the State Disability Insurance office. Responses will appear in the Inbox in the Message Center.

Add a Treatment Address



MAIN MENU

[Home](#)
[Inbox](#)
[Saved Drafts](#)
[Manage My Profile](#)
[Sign Out](#)

Home

*Indicates Required Field

License Information

Licensee Name

License Number

Message Center

[Inbox](#) [New: 0 , Total: 0]

[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Receipt Number. claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.

To add a treatment address:

- Select **Manage My Profile** under the Main Menu on the **Home** page.

CA.GOV **EDD** Employment Development Department State of California [Skip to main content](#)

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile
- Contact Us

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment Address**
- Manage Medical Representative

Physician/Practitioner Update Personal Profile Information

**Indicates Required Field*

Physician/ Practitioner Information

Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs updated address when the next license validation is done.

Treatment Address

Treatment Address

You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.

No Results Found

Add

You will be directed to the **Physician/Practitioner Update Personal Profile Information** screen.

- Select **Manage Treatment Address** from the Page Menu.
- Users can add a treatment address by selecting the **Add** button.

Add Modify Treatment Address

*Indicates Required Field

Add/Modify Treatment Address

☒ US ☐ International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

*Phone Number: Ext ☐ Check here if the phone number is international

Save Cancel

On the **Add Modify Treatment Address** screen:

- Complete all fields and select **Save**.

Note: Users will need to repeat this process to add all treatment addresses at which they practice.

MAIN MENU

Home

Manage My Profile

Contact Us

PAGE MENU

Change Security Questions

Change Password

Change Personal Image

Manage Treatment Address

Manage Medical Representative

Utilities

Treatment Address

Treatment Address

You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.

| Address | Phone Number | Action |
|-----------------------------------|--------------|---|
| 123 Main St. Anytown, CA 95814 | 000-000-0000 | Modify Delete |

Add

The user is directed to the **Treatment Address** screen.

- Once the treatment addresses are added, they will display on this screen.
- Users can select the **Modify** or **Delete** link to manage their treatment addresses.

Assign a Medical Representative



MAIN MENU

[Home](#)
[Inbox](#)
[Saved Drafts](#)
[Manage My Profile](#)
[Contact Us](#)

Home

*Indicates Required Field

License Information

| Licensee Name | License Number |
|---------------|----------------|
|---------------|----------------|

Message Center

[Inbox](#) [New: 0 , Total: 0]
[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Receipt Number. To obtain information regarding forms previously submitted, search by My Receipt Number.

*Search By:
*Patient Last Name:

Search Results

Medical representatives can complete and submit forms on behalf of the registered physician/practitioner once they have been added to the account.

To add a medical representative, from the **Home** screen:

- Select **Manage My Profile** under the Main Menu.

MAIN MENU

Home
Inbox
Saved Drafts
Manage My Profile
Contact Us

PAGE MENU

Change Security Questions
Change Password
Change Personal Image
Manage Treatment Address
Manage Medical Representative

Physician/Practitioner Update Personal Profile Information

*Indicates Required Field

Physician/ Practitioner Information

Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs (DCA). DCA will provide EDD with your updated address when the next license validation is done.

Licensee Name:

License Type: Physician or Surgeon (MD)

Physician/Practitioner Information

Medical Representative Information

You may have no more than seven (7) representatives who may access your certification information and assist in completing the forms. Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.

No Results Found

Med

Me

*Re-Type

National

Communicate

Indicate below

*Preferred Communication:

☐ I prefer to be notified by e-mail.

☐ I prefer to be notified by paper mail

☒ I do not want to receive notifications. I will be reviewing the items in my message center regularly

The Physician/Practitioner Update Personal Profile Information screen appears.

- Select **Manage Medical Representative** from the Page Menu.
- From the **Add Delete Medical Representative** screen, select the **Add** button.

Add Modify Medical Representative

*Indicates Required Field

Add Representative

*First Name:

Middle Name:

(if the medical representative has no middle name, leave blank)

*Last Name:

Suffix:

(if the medical representative has no suffix, leave blank)

*Last 4 Digits of Social Security Number:

*E-mail Address:

*Re-Type E-mail Address:

*Date of Birth: (MM/DD/YYYY)

*Treatment Address: 800 Capitol Mall Sacramento CA 95814-4807 ☒

*Account Status: Active ☒

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

On the **Add Modify Medical Representative** screen:

- Complete all required fields.
- User will need to select a treatment address where the representative will be providing treatment.
- Select **Save**.

Add Delete Medical Representative

Medical Representative Information

You may have no more than seven (7) representatives who may access your certification information and assist in completing the forms. Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.

| Name | Last 4 Digits of Social Security Number | E-mail Address | Date of Birth | Treatment Address | Account Status | Action |
|----------|---|-----------------|---------------|---|----------------|--|
| Jane Doe | 1234 | email@email.com | 01-01-1950 | 800 Capitol Mall Sacramento CA 95814-4807 | Active | Modify Delete |

[Add](#)

Once the medical representatives are added, they will display on the **Add Delete Medical Representative** screen.

- Users can select the **Modify** or **Delete** link to manage their added representatives.

Submit a DE 2501 Part B – Physician/Practitioner Certificate

Home

*Indicates Required Field

License Information

| Licensee Name | License Number |
|---------------|----------------|
| Jane Doe | CA00000 |

Message Center

[Inbox](#) [New: 0 , Total: 0]
[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Receipt Number. To locate the claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.

*Search By:
*Patient Last Name:

Search Results

| Receipt Number | Patient Name | Date of Birth | Action |
|----------------------------------|--------------|---------------|---|
| R100000000033909 | John Doe | 01-01-1950 | Submit Physician/Practitioner Certificate |

Note: if the Certificate is already submitted by another user (i.e., medical representative), the **Submit Physician/Practitioner Certificate** link will not be available.

To submit a DE 2501 Part B – Physician/Practitioner Certificate:

- Search by “Patient Receipt Number” and patient last name.
- Verify the information in the Search Results section matches the claimant’s records.
- The **Receipt Number** link will allow the user to view what the claimant submitted on their portion of the DE 2501 Part A - Claimant Statement.
- Select **Submit Physician/Practitioner Certificate** under the Action column.

View Claimant Portion

View Claimant DE 2501

Refer to the *Claim for Disability Insurance (DI) Benefits* (DE 2501) Claimant's Statement while completing this form. To open the Claimant's Statement, click the link below and it will open in a new window.

[View the Claim for Disability Insurance \(DI\) Benefits Claimant \(DE 2501\)](#)

Next

Cancel

You will first be taken to the **View Claimant Portion** screen:

- The link allows the user to view the claimant portion of the form.
- Once the user selects **Next**, they will begin completing the certificate.

CA.GOV EDD Employment Development Department State of California [Skip to main content](#) [Help](#) | [Logout](#)

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile
- Contact Us

Treatment Address

1 → 2 → 3 → 4
Treatment Address Patient Information Claim Information Declaration

You are currently on step 1 of 4: Treatment Address

Section 2B - Treatment Address

If the patient was treated at an address other than those shown below, navigate to your profile and add the treatment address.

| Address | Action |
|-----------------------------------|------------------------|
| 123 Main St. Anytown, CA 95814 | Select |

[Previous](#) [Not Found](#) [Cancel](#)

- To begin the certificate, select the treatment address of where the patient is being treated.
- When the user is submitting a form, there will be a number of bubbles at the top of the page to indicate the step the user is on at any given moment.
- Each step will have a title to indicate the section the user is in.

You are currently on Step 2 Patient Information

*Indicates Required Field

Section 1 - Patient Information

Patient's Name: John Doe Receipt Number: R100000000035336
Social Security Number: Date of Birth: (MMDDYYYY)
File Number:

Section 2A - Physician/Practitioner Information

Name: Jane Doe Treatment Address 123 Main St.
Anytown, CA 95814
License Number: CA00000 State of Licensure: CA
Country of Licensure: United States
*Phone Number: Ext: ☐ Check here if the phone number is international
(No dashes or spaces)
Type: Physician or Surgeon (MD) Specialty (if any):

Section 3 - Treatment Information

This patient has been under my care and treatment for this medical problem:
*From: (MMDDYYYY) To: (MMDDYYYY)
*Are you presently treating the patient for this medical condition? ☐ Yes ☐ No
Treatment Intervals: Select
*Was the patient seen previously by another physician/practitioner or
medical facility for the current disability/illness/injury? Select
If "Yes," enter date of first treatment: (MMDDYYYY)
*At any time during your attendance for this medical problem, has the patient been incapable of ☐ Yes ☐ No
performing his/her regular or customary work?

Previous

Next

Save as Draft

Cancel

When completing the initial claim form:

- Users can select the **Save as Draft** button at any time.
- **Do not use the Back button on the browser.** If the user needs to go to a previous screen, select the **Previous** button.
- There are several mandatory fields that must be completed before the form can be submitted. These fields contain a red asterisk.

You are currently on Step 3 Claim Information

***Indicates Required Field**

Section 4A - Claim Information

*Date Disability Began: (MMDDYYYY)

Indicate if the disability was caused by accident or trauma; and if so, indicate the date the accident or trauma occurred below:

*Accident or trauma? ☐ Yes ☐ No Date occurred: (MMDDYYYY)

For non-pregnancy related claims, you must provide the following date or indicate the disability is permanent.

Date you released or anticipate releasing patient to return to his/her regular or customary work: (MMDDYYYY)

Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work: ☐

Enter the ICD Diagnosis Code and version for the primary disabling condition that prevents the patient from performing his/her regular or customary work below:

*ICD Diagnosis Code: *Diagnosis Code Version:

ICD Diagnosis Code(s) for Secondary Disabling Condition(s):

| | |
|--|---|
| ICD Diagnosis Code: <input type="text"/> | Diagnosis Code Version: <input type="text" value="Select"/> |
| ICD Diagnosis Code: <input type="text"/> | Diagnosis Code Version: <input type="text" value="Select"/> |
| ICD Diagnosis Code: <input type="text"/> | Diagnosis Code Version: <input type="text" value="Select"/> |

*Diagnosis - If no diagnosis has been determined, enter a detailed statement of symptoms:

Findings - State nature, severity, and extent of the incapacitating disease or injury, include any other disabling conditions:

When completing the initial claim form:

- SDI Online will accept valid ICD 9 and ICD 10 codes.
- If the patient's disability is diagnosed as permanent, the user should still provide a date in the "Date you released or anticipate releasing patient to return to his/her regular customary work" field.
 - Example: If the disability is permanent, enter a date in the far future, such as 01-01-2050.

Type of treatment/medication rendered to patient:

If the patient was hospitalized, enter the date of entry, date of discharge and whether the patient is still hospitalized below:

Date of entry: (MMDDYYYY) Date of discharge: (MMDDYYYY)

Patient is still hospitalized? ☐ Yes ☐ No Check here if the patient is deceased: ☐

Date of death: (MMDDYYYY) City: State: Select

Country: State: Select

Enter type and date of surgery/procedure most recently performed or to be performed below:

Type: Date: (MMDDYYYY)

Enter the ICD Procedure Code and version for surgery/procedure(s) planned or performed below:

| | |
|---------------------|--------------------------------|
| ICD Procedure Code: | Procedure Code Version: Select |
| ICD Procedure Code: | Procedure Code Version: Select |
| ICD Procedure Code: | Procedure Code Version: Select |
| ICD Procedure Code: | Procedure Code Version: Select |

Enter the CPT code for surgery/procedure(s) planned or performed below:

| | |
|-----------|-----------|
| CPT Code: | CPT Code: |
| CPT Code: | CPT Code: |

Was the patient unable to work immediately prior to the surgery or procedure? ☐ Yes ☐ No

If "Yes," please provide the first date the patient was unable to work prior to the surgery or procedure: (MMDDYYYY)

If this patient has not delivered and you do not anticipate releasing the patient to return to regular or customary work prior to the estimated delivery date, provide estimates for the number of days you anticipate the patient will be disabled after delivery for both of the following delivery types:

Vaginal delivery: Cesarean delivery:

If this patient has delivered, indicate type of delivery and any complications as applicable.

Type of delivery: Select

If pregnancy is/was abnormal, state the complication(s) causing maternal disability:

Previous Next Save as Draft Cancel

Physicians/practitioners can provide an estimated number of days they anticipate the patient to be disabled postpartum.

➤ Example: If the doctor is allowing the claimant 6-8 weeks of postpartum disability, depending on the delivery type, then:

- Enter the number 42 in the Vaginal Delivery field (6 weeks x 7 days a week = 42)

AND

- Enter the number 56 in the Cesarean Delivery field (8 weeks x 7 days a week = 56).

Once the **Next** button is selected, if there is anything to be verified the system will prompt the user.

You are currently on Step 4 Declaration

Section 7 - Certification

All Persons Authorized to Certify:

- ☐ All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dentist, Podiatrist, Optometrist, Designated Psychologist): I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and I have treated the patient within my scope of practice.
- ☐ Nurse Practitioner: I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and I have treated the patient within my scope of practice. If for a condition other than a normal pregnancy or delivery, I certify that I have performed a physical examination and have collaborated with a physician and surgeon.
- ☐ Registrar of a county hospital in California or medical officer of US Government medical facility: I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and these conditions are shown by the patient's hospital chart.
- ☐ Other

Title of the person if not covered above (must be able to legally certify to a disability):

To review your information before you submit, select the hyperlink below. Your information will display below the Claimant's Statement.

[View the *Claim for Disability Insurance \(DI\) Benefits Physician/Practitioner Certification* \(DE 2501\)](#)

Previous

Submit

Save as Draft

Cancel

Confirmation

Confirmation

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Claim for Disability Insurance (DI) Benefits* (DE 2501). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Form Receipt Number: [R100000000035344](#)

Certifying for the disability:

- Once the form is completed, the user will need to select the option in Section 7 – Certification that best describes their role.
- Before submitting the form, the user will have the option of viewing the form by selecting the link at the bottom of the page.
- Once the form is submitted, the user will be taken to the **Confirmation** screen to get a Form Receipt Number.

**Submit a DE 2525xx
Supplementary Certificate to
Continue Benefits**



MAIN MENU

[Home](#)
[Inbox](#)
[Saved Drafts](#)
[Manage My Profile](#)
[Contact Us](#)

Home

*Indicates Required Field

License Information

| Licensee Name | License Number |
|---------------|----------------|
| Jane Doe | CA00000 |

Message Center

[Inbox](#) [New: 0 , Total: 0]

[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Rec claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.

*Search By:

*Patient Last Name:

Search Results

| Claim ID | Patient Name | Date of Birth | Claim Effective Date | Claim |
|------------------------------|--------------|---------------|----------------------|-------|
| DI1000000012 | John Doe | 01-01-1950 | 03-25-2012 | Disab |

To submit a Supplementary Certificate:

- Search by "Claim ID" and patient last name.
- Verify the claimant information in the Search Results.
- Select the **Claim ID** to view the claim information.



MAIN MENU

[Home](#)
[Inbox](#)
[Saved Drafts](#)
[Manage My Profile](#)
[Contact Us](#)

Claim Summary

Claim Summary

Claimant Name: John Doe

Claim ID: DI-1000-000

Claim Effective Date: 03-25-2012

My Message Center Regarding John Doe

[Inbox](#) [New: 0, Total: 0]

[Saved Drafts](#) [Total: 0]

My Forms Available to Submit for John Doe

Below is a list of forms available for submission. Please note that not all forms will be available at all times.

[DE 2525XX](#)

My Forms Submitted for John Doe

No Results Found

Claim information is on the Claim Summary screen.

- Under the My Forms Available section, the user will be able to view all available medical forms to submit for the claimant.
- Select the form you want to complete.

Physician/Practitioner Supplementary Certificate (Part 1)

*Indicates Required Field

Section 1 - Physician/Practitioner Information

Name: Jane Doe

License Number: CA00000

Section 2 - Patient Information

Patient Name: John Doe

Date of Birth: 01-01-1950

Social Security Number: XXX-XX1234

Claim ID: DI-1000-

Claim Effective Date: 07-23-2012

Section 3 - Form Information

Please complete and submit this information by the due date.

Issue Date:

Due Date:

Section 4A - Physician/Practitioner's Supplementary Certificate

Patient File Number:

Specialty, if any:

*Are you still treating the patient? ☐ Yes ☐ No

*Date of last treatment: (MMDDYYYY)

Next Appointment Date: (MMDDYYYY)

What present condition continues to make the patient disabled?

Enter the ICD
customary work

ICD Dia

Enter the ICD Diagnosis Code and version for secondary disabling condition (s) that prevents the patient from performing his/her regular or customary work below:

ICD Diagnosis Code:

Diagnosis Code Version: Select

ICD Diagnosis Code:

Diagnosis Code Version: Select

ICD Diagnosis Code:

Diagnosis Code Version: Select

Describe how the patient's present condition/impairment prevents him/her from returning to his/her regular or customary work.

What factors or complications are disabling the patient longer than previously estimated for this type of illness or injury?

Next

Save as Draft

Cancel

The selected form appears.

- Enter the data requested and continue to the following screen by selecting the **Next** button.
- Or use the **Save as Draft** button to save the data and return to complete the form later.

Mandatory fields are indicated with a red asterisk.

Physician/Practitioner Supplementary Certificate (Part 2)

*Indicates Required Field

Section 4B - Physician/Practitioner's Supplementary Certificate

*Was the patient hospitalized? ☐ Yes ☐ No

If "Yes," provide the following:

Date of Entry: (MMDDYYYY)

Date of Discharge: (MMDDYYYY)

☐ Check here if patient is still hospitalized

*Was surgery/procedure performed, or will a surgery/procedure be performed? ☐ Yes ☐ No

If "Yes," type of surgery/procedure:

Date of surgery/procedure: (MMDDYYYY)

Enter the ICD Procedure Code and version for the surgery/procedure(s) planned or performed below:

ICD Procedure Code:

Procedure Code Version:

ICD Procedure Code:

Procedure Code Version:

ICD Procedure Code:

Procedure Code Version:

ICD Procedure Code:

Procedure Code Version:

Enter the CPT Code for the surgery/procedure(s) planned or performed below:

CPT Code:

CPT Code:

CPT Code:

CPT Code:

Present estimated date patient will be able to perform his/her regular or customary work: (MMDDYYYY)

Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work. ☐

*Would the disclosure of this information to your patient be medically or psychologically detrimental? ☐ Yes ☐ No

[Previous](#)

[Next](#)

[Save as Draft](#)

[Cancel](#)

Continue entering information as appropriate.

Every page will have the option to **Save as Draft**.

Or select **Next** to continue completing the form.

MAIN MENU

Home
Inbox
Saved Drafts
Manage My Profile
Contact Us

Submit Form

Section 5 - Certification

Submitted by: Jane Doe

☐ All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dentist, Podiatrist, Optometrist, Psychologist)

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and I have treated the patient within my scope of practice.

☐ Nurse Practitioner

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and I have treated the patient within my scope of practice. If for a condition other than a normal pregnancy or delivery, I certify that I have performed a physical examination and have collaborated with a physician and surgeon.

☐ Registrar of a County Hospital in California or Medical Officer of a US Government Medical Facility

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and these conditions are shown by the patient's hospital chart.

☐ Other

Title of person if not covered above (must be able to legally certify to a disability):

[Previous](#)

[Submit](#)

[Save as Draft](#)

[Cancel](#)

To submit the form, select the certification type and the **Submit** button.

- The user will be taken to the **Confirmation** page and provided with a Form Receipt Number.

Confirmation

Form Successfully Submitted

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Physician/Practitioner's Supplementary Certificate* (DE 2525XX). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Form Receipt Number [3100000000061009](#)



MAIN MENU

[Home](#)
[Inbox](#)
[Saved Drafts](#)
[Manage My Profile](#)
[Contact Us](#)

Claim Summary

Claim Summary

Claimant Name: John Doe

Claim ID: DI-1000-000-I

Claim Effective Date: 03-25-2012

My Message Center Regarding John Doe

[Inbox](#) [New: 0, Total: 0]

[Saved Drafts](#) [Total: 0]

My Forms Available to Submit for John Doe

Below is a list of forms available for submission. Please note that not all forms will be available at all times.

[DE 2525XX](#)

My Forms Submitted for I John Doe

Form Name

[2525XX Supplemental Medical Cert](#)

Receipt Number

R100000000000

Submitted Date

11-09-2012

On the **Claim Summary** page:

- All forms submitted by the user will appear in the My Forms Submitted section.

Visit www.edd.ca.gov for more information about
State Disability Insurance.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-800-480-3287 (voice), or TTY 1-800-563-2441.